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# Clitoral Pain and Dyspareunia after Female Genital Mutilation/Cutting: A Case Report

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## Abstract

Background: Current evidence has focused on the complications of female genital mutilation/cutting (FGM/C) types 2 and 3, and there is a gap in the knowledge of the complications of FGM/C types 1 and 4, which are often considered milder forms of cutting. Case Presentation: A 23-year-old Somali woman with FGM/C was referred for chronic clitoral pain and superficial dyspareunia after several inconclusive gynecological examinations. Her clitoris was found to be entrapped under the scar of the cut clitoral hood. We surgically lysed the scar and reconstructed a prepuce. At the two-month follow-up, the patient reported no pain and physiologic sexual response. Conclusion: Clitoral pain and dyspareunia after FGM/C can be due to the incarceration of the clitoral glans. Treatment is surgical lysis of the scar.

## Keywords

Female Genital Mutilation/Cutting (FGM/C), Dyspareunia, Clitorodynia

## 1. Background

Female Genital Mutilation or Cutting (FGM/C) is any procedure involving the removal or alteration of external genitalia for non-medical reasons. Documented short- and long-term consequences of FGM/C include genitourinary, obstetric, and psychosexual complications, as well as infection, scarring, and pain [1] [2] [3]. The available evidence has focused more on the complications of FGM/C types 2 and 3, and there is a gap in the knowledge of the complications of FGM/C types 1 and 4 [4].

Dyspareunia after FGM/C can be: 1) superficial in the case of infibulation, obstetric trauma, and vulvar scar tissue or bridles (stringy adhesions at localized

points) or 2) deep after recurrent genital infections that might lead to pelvic inflammatory disease [5] [6] [7]. Dyspareunia can be associated with primary or secondary vaginismus and be part of a genito-pelvic pain/penetration disorder. Superficial dyspareunia may have vulvar, clitoral, and/or psychosexual causes [8]. Clitoral pain during sex or otherwise can be present in the case of post-traumatic neuromas of the clitoris, vulvar or clitoral cysts, abscesses, keloids, or scarring [9].

Non-surgical methods of addressing clitoral pain include the use of painkillers, psychosexual therapy, topical analgesics, and pelvic floor therapy. Surgical methods include excision of scar tissue, keloids, neuromas, and cysts and restoration of normal anatomy, such as clitoral reconstruction in the case of FGM/C involving the clitoral glans [10]. However, the evidence for these treatments comes mainly from case reports and case series [9] [10]. A recent systematic review on surgical and nonsurgical interventions for vulvar and clitoral pain in girls and women living with FGM/C was unable to include any studies and indicated this area as an important field of research [9].

The present case study details the presentation and successful treatment of a woman with a form of FGM/C without cutting of the clitoris who experienced clitoral pain and superficial dyspareunia in the clitoral area. To our knowledge, this is the first case report of a woman with a painful clitoral incarceration after undergoing a form of FGM/C that did not involve the cutting of the clitoral glans.

## 2. Case Presentation

A 23-year-old nulligravida Somali woman with a history of FGM/C during childhood was referred to our specialized outpatient clinic for women and girls with FGM/C for chronic clitoral pain and dyspareunia. She had been experiencing pain for at least eight months and had seen several gynecologists without a conclusive diagnosis or treatment.

General physical examination was normal, with no remarkable medical history besides the FGM/C, from which there had been no prior reported short- or long-term complications besides the clitoral pain. Upon exam, classification of her FGM/C was not trivial. It could appear to be a type 1b because the scar from the cutting completely covered the glans of the clitoris, or type 2b because the scar involved the upper part of the labia minora (**Figure 1**). There was no narrowing of the vaginal orifice, nor covering of the urethral meatus. Careful examination revealed that the patient had undergone FGM/C that involved the cutting of the clitoral hood with probable stitching of the prepuce. The glans of the clitoris was intact but incarcerated by the scar (**Figure 1**). A q-tip test revealed that most of the patient's pain was localized at the level of the 11 o'clock clitoral bridle (**Figure 2**).

The patient also referred to vulvar and vaginal dryness during sex that contributed to her dyspareunia. Clitoral phimosis and vulvar dryness are often

symptoms of Lichen Sclerosus (LS), but there were no clinical signs of LS in our patient.

We surgically liberated the clitoris under general anesthesia (**Figure 3**) with a laryngeal mask to avoid pain and experiences that might recall the event of FGM/C [11]. The scar was placed under tension and sectioned with Iris scissors, releasing an intact glans of the clitoris and reconstructing a prepuce (**Figure 4(a)**). There were no intraoperative complications.

The patient was advised to take 1 g of acetaminophen four times per day for pain management and apply Chlorhexidine 0.1% to the surgical area for seven days. In addition, she was instructed to apply local estriol cream one time per day for the first week and two times per week for the following three weeks. We recommended that the patient not engage in sexual or strenuous activities for one month. The post-operative follow-up was uneventful. At the two-month post-operative follow-up (**Figure 4(b)**), the patient had resumed daily activities and sexual intercourse without pain. She reported sexual arousal, pleasure, and orgasm and was highly satisfied with the results.

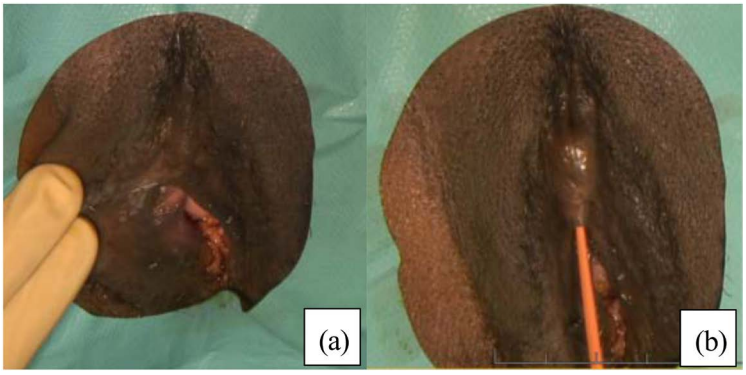


**Figure 1.** Female Genital Mutilation/Cutting (FGM/C) involving the cutting and probable stitching of the clitoral hood, without the cutting of the clitoral glans (a). A q-tip can be inserted under the scar above the glans of the clitoris, which is incarcerated and chronically painful (b).

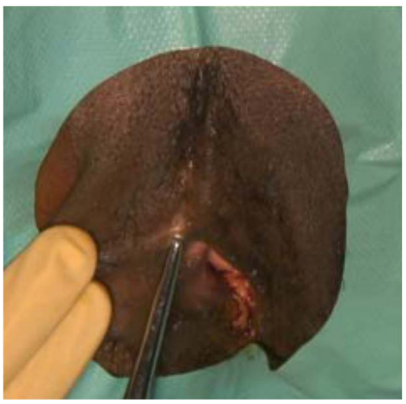

**Figure 2.** Symptoms reported by the patient were chronic clitoral pain and superficial dyspareunia in the clitoral region. The clamp shows the region described as most painful (right scar bridle).

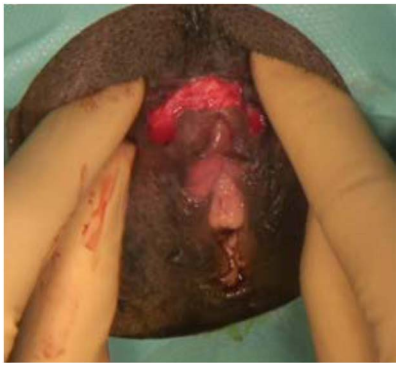

**Figure 3.** Surgical lysis of the scar, releasing an intact clitoral glans.

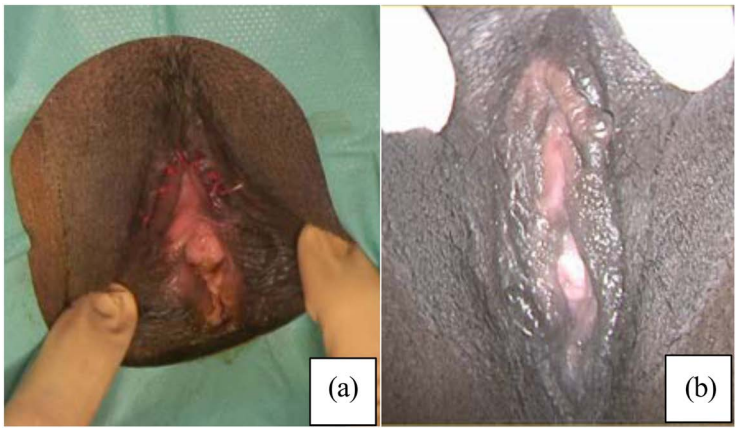


**Figure 4.** Immediate (a) and 2 months (b) post-operative appearance. Exposure of the intact clitoral glans and reconstruction of the prepuce of the clitoris.

## 3. Discussion

This case study addresses two current research gaps: long term complications of FGM/C that does not involve cutting of the clitoris, and treatments for pain after FGM/C. We also establish that painful incarceration of the clitoral glans is a possible long-term consequence of FGM/C and that pain is successfully treated by lysing the adhesions around the clitoral glans.

Clitoral adhesions and phimosis have been reported in conditions such as Lichen Sclerosus (LS), genital trauma, chronic infections, and low calculated free testosterone. These adhesions can cause irritation, infection, hypersensitivity, dyspareunia, balanitis, or persistent genital arousal disorder and are treated by surgical lysis with high degrees of success, as in our case [1] [12] [13] [14]. Lysis by Jacobsen mosquito forceps is often sufficient in conditions such as LS, although dorsal slits made with Iris scissors may be needed in the case of recurrent adhesions or phimosis [12] [15].

The present case study also informs the understanding of the possible pathophysiological mechanisms of clitoral cysts as a long-term consequence of FGM/C. While clitoral bridles/phimosis have never been described in patients

with FGM/C, several cases of clitoral cysts post-FGM/C have been reported [16] [17]. It can be hypothesized that some clitoral cysts after FGM/C might result from smegma accumulation under the phimosis, similar to those cysts reported in Lichen Sclerosus (LS) and clitoral and penile phimosis [18].

Clitoral pain and dyspareunia were easily alleviated and quality of life improved by conducting a simple surgical procedure that relieved the tension imposed on the clitoral glans by the FGM/C scar. We did not perform any additional surgical procedure, as performing surgery in the clitoral area is not without risk; extreme consequences could include nerve damage that results in chronic pain or reduced sexual response [19].

## 4. Conclusions

The subject of the study has a scar incarcerating the clitoris due to a form of FGM/C that might be considered milder as it involved cutting and probable stitching the prepuce but the glans of the clitoris was not cut. However, the scar caused clitoral pain and dyspareunia. Treatment of the clitoral incarceration was surgical lysis of the scar.

Our case study emphasizes the need for healthcare provider education regarding FGM/C and its consequences for a quick diagnosis and treatment. Our patient underwent several exams over a period of many months and had to be referred to a specialized clinic to obtain diagnosis and treatment.

## Author's Contributions

DH provided the patient referral to JA. JA made the diagnosis, performed the surgery, and followed the patient post-op. JA and EM wrote the manuscript.

## Ethics Approval and Consent to Participate

The patient gave her consent for the procedure and for the pictures to be published.

## Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

## References

[1] Berg, R.C., Odgaard-Jensen, J., Fretheim, A., Underland, V. and Vist, G. (2014) An Updated Systematic Review and Meta-Analysis of the Obstetric Consequences of Female Genital Mutilation/Cutting. *Obstetrics and Gynecology International*, **2014**, Article ID: 542859. https://doi.org/10.1155/2014/542859

[2] Berg, R.C. and Underland, V. (2013) The Obstetric Consequences of Female Genital Mutilation/Cutting: A Systematic Review and Meta-Analysis. *Obstetrics and Gynecology International*, **2013**, Article ID: 496564.

[3] Berg, R.C., Denison, E. and Fretheim, A. (2010) Psychological, Social, and Sexual Consequences of Female Genital Mutilation/Cutting (FGM/C): A Systematic Re-

view of Quantitative Studies. Norwegian Knowledge Centre for the Health Services, No. 13-2010.

[4] Abdulcadir, J., Rodriguez, M.I. and Say, L. (2014) Research Gaps in the Care of Women with Female Genital Mutilation: An Analysis. *BJOG*: *An International Journal of Obstetrics and Gynecology*, **122**, 294-303. https://doi.org/10.1111/1471-0528.13217

[5] Abdulcadir, J., Catania, L., Hindin, M.J., Say, L., Petignat, P. and Abdulcadir, O. (2016) Female Genital Mutilation: A Visual Reference and Learning Tool for Health Care Professionals. *Obstetrics and Gynecology*, **128**, 958-963. https://doi.org/10.1097/AOG.0000000000001686

[6] Nour, N.M., Michels, K.B. and Bryant, A.E. (2006) Defibulation to Treat Female Genital Cutting: Effect on Symptoms and Sexual Function. *Obstetrics and Gynaecology*, **108**, 55-60. https://doi.org/10.1097/01.AOG.0000224613.72892.77

[7] Catania, L., Abdulcadir, O., Puppo, V., Verde, J.B., Abdulcadir, J. and Abdulcadir, D. (2007) Pleasure and Orgasm in Women with Female Genital Mutilation/Cutting (FGM/C). *Journal of Sexual Medicine*, **4**, 1666-1678. https://doi.org/10.1111/j.1743-6109.2007.00620.x

[8] Reisel, D. and Creighton, S. (2014) Long Term Health Consequences of Female Genital Mutilation. *Maturitas*, **80**, 48-51. https://doi.org/10.1016/j.maturitas.2014.10.009

[9] Ezebialu, I., Okafo, O., Oringanje, C., Ogbonna, U., Udoh, E., Odey, F. and Meremikwu, M. (2017) Surgical and Nonsurgical Interventions for Vulvar and Clitoral Pain in Girls and Women Living with Female Genital Mutilation: A Systematic Review. *International Journal of Gynecology & Obstetrics*, **136**, 34-37. https://doi.org/10.1002/ijgo.12048

[10] Abdulcadir, J., Tille, J.C. and Petignat, P. (2017) Management of Painful Clitoral Neuroma after Female Genital Mutilation/Cutting. *Reproductive Health*, **14**, 22. https://doi.org/10.1186/s12978-017-0288-3

[11] Abdulcadir, J., Bianchi Demicheli, F., Willame, A., Recordon, N. and Petignat, P. (2017) Posttraumatic Stress Disorder Relapse and Clitoral Reconstruction After Female Genital Mutilation. *Obstetrics and Gynecology*, **129**, 371-376. https://doi.org/10.1097/AOG.0000000000001835

[12] Hayashi, Y., Kojima, Y., Mizuno, K. and Kohri, K. (2011) Prepuce: Phimosis, Paraphimosis, and Circumcision. *The Scientific World Journal*, **11**, 289-301. https://doi.org/10.1100/tsw.2011.31

[13] McGregor, T.B., Pike, J.G. and Leonard, M.P. (2007) Pathologic and Physiologic Phimosis. *Canadian Family Physician*, **53**, 445-448.

[14] Flynn, A.N., King, M., Rieff, M., Krapf, J. and Goldstein, A.T. (2015) Patient Satisfaction of Surgical Treatment of Clitoral Phimosis and Labial Adhesions Caused by Lichen Sclerosus. *Journal of Sexual Medicine*, **3**, 251-255. https://doi.org/10.1002/sm2.90

[15] Aerts, L., Rubin, R.S., Randazzo, M., Goldstein, S.W. and Goldstein, I. (2018) Retrospective Study of the Prevalence and Risk Factors of Clitoral Adhesions: Women's Health Providers Should Routinely Examine the Glans Clitoris. *Journal of Sexual Medicine*, **6**, 115-122. https://doi.org/10.1016/j.esxm.2018.01.003

[16] Uppmg, W.C., Shakya, R., Sanders, B.T. and Lind, J. (2004) Clitoral Inclusion Cyst: A Complication of Type 1 Female Genital Mutilation. *Journal of Obstetrics and Gynaecology*, **24**, 98-99. https://doi.org/10.1080/01443610310001627254

[17] Rouzi, A.A., Sindi, O., Radhan, B. and Ba'aqueel, H. (2001) Epidermal Clitoral In-

clusion Cyst after Type 1 Female Genital Mutilation. *American Journal of Obstetrics and Gynecology*, **185**, 569-571. https://doi.org/10.1067/mob.2001.117660

[18] Selco, M.M., Doss, R.H., Gruber, D.D. and Shippey, S.H. (2013) Labial Fusion Causing Recurrent Cyst Formation and a Novel Approach to Surgical Management. *Female Pelvic Medicine and Reconstructive Surgery*, **19**, 312-314. https://doi.org/10.1097/SPV.0b013e318292460e

[19] Berg, R.C., Taraldsen, S., Said, M.A., Sørbye, I.K. and Vangen, S. (2017) The Effectiveness of Surgical Interventions for Women with FGM/C: A Systematic Review. *BJOG*: *An International Journal of Obstetrics and Gynecology*, **125**, 278-287. https://doi.org/10.1111/1471-0528.14839

## List of Abbreviations

**FGM/C**: Female Genital Mutilation/Cutting

**LS**: Lichen Sclerosus